DELTA DENTAL®

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1699

# EMPLOYEE/RETIREE ENROLLMENT AND CHANGE FORM

☐ New Enrollment
☐ Change
☐ Open Enrollment

**Sublocation Number**
☐ 0001 – Active
☐ 0003 - Retirees

**Group Name/ Group Number**
**Shelby County Government/5319**

| |
|---|
| **SOCIAL SECURITY NUMBER (must be 9 digits)** |
| **FIRST NAME** |
| **LAST NAME** |
| **STREET ADDRESS** |
| **CITY** **STATE** **ZIP** |

| Birth Date | Sex M ☐ F ☐ | Hire Date | Work/Home Number | Department | Effective Date (Do not Complete- Benefits Use Only) |
|---|---|---|---|---|---|
| | | | | | |

**If enrolling OR dropping spouse and/or dependents please list them below and check appropriate box. Attach another form for additional dependents.**

| FIRST NAME & M.I. (LAST NAME IF DIFFERENT) | Birth Date | Sex | | Check One | | Effective Date (Do not Complete- Benefits Use Only) |
|---|---|---|---|---|---|---|
| | | M | F | Add | Drop | |
| **SPOUSE:** | | | | | | |
| **CHILD:** | | | | | | |
| **CHILD:** | | | | | | |
| **CHILD:** | | | | | | |
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| **CHILD:** | | | | | | |

**Based on the above change, new coverage is:** ☐ **EE** ☐ **EE+1** ☐ **FAMILY**

☐ **Cancel Coverage (ONLY CHECK IF CANCELING YOUR ENTIRE DENTAL PLAN) Cancel Date: _____**

CHANGE NAME From:_____ To:_____

CHANGE ADDRESS To: _____

_____

I agree to complete proper forms and provide proof of relationship (i.e. birth certificate, marriage license, etc.) to add/delete eligible or ineligible dependents, as required. I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: _____ Date: _____

| For Office Use Only | EIN: | Entered By: | Comments | DDPT – Shelby Co Gov (10/12) |
|---|---|---|---|---|
| | | | | |